

international normalised ratios because of the low rate of remuneration for tests.

Currently we do not know why doctors and patients fail to implement the findings from anticoagulation trials. A better understanding of what factors actually influence patients' and doctors' behaviour in this area is needed, so that effective strategies can be implemented.

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## How to improve communication between doctors and patients

*Learning more about the decision making context is important*

Communication difficulties between doctors and patients have been looked at by researchers from several disciplines who have tried to explore why these occur. Mishler, for example, has argued that doctors and patients talk to each other with different voices.<sup>1</sup> The voice of medicine is characterised by medical terminology, objective descriptions of physical symptoms, and the classification of these within a reductionist biomedical model.<sup>1</sup> The voice of patients, on the other hand, is characterised by non-technical discourse about the subjective experience of illness within the context of social relationships and the patient's everyday world. Typically, doctors have more power than patients to structure the nature of the interaction between them. As a consequence, patients may feel that their voice is overridden, silenced, or stripped of personal meaning and social context. To improve communications between doctors and patients we need also to understand the nature of the decision making that is taking place in the consultation.

Two recent papers in the *BMJ*, one of them published this week (p 1246), focus on the type and frequency of communication misunderstandings experienced by general practitioners and their patients in 20 English general practices.<sup>2,3</sup> The prevalence of these misunderstandings among presumably well intentioned doctors and their patients is alarming, particularly given their effects on subsequent patient behaviour.

In their first paper the authors presented findings about communication misunderstandings associated with prescribing decisions.<sup>2</sup> Fourteen categories of misunderstandings between doctors and patients were identified, each of which had potential or actual adverse consequences for medicine taking. All were associated with a lack of patient participation in

decision making in terms of voicing expectations or preferences or voicing responses to their doctor's actions.

In this week's paper the authors explore the agendas that patients bring for discussion with their doctor at a forthcoming consultation; those aspects of patients' agendas that they actually voiced in the consultation; and the effects of unvoiced agendas on patients' subsequent behaviour.<sup>3</sup> Most patients did not voice all their agenda items, though it is important to note that these items were generated during a qualitative interview, which is longer and more open ended than a normal consultation. Unvoiced agenda items led to specific problems such as unwanted prescriptions and non-adherence.

The authors recommend that efforts should be made to improve communication between doctors and patients in the treatment decision making process, and they are developing educational interventions targeted at doctors to address these issues. Patient focused interventions, although not mentioned, are also likely to help patients voice their agendas. A potential limitation of the research is that it is not clear how many of the consultations studied represented repeat visits to a doctor with whom the patients had a continuing relationship. This is important because unspoken agendas may have been covered in an earlier visit (and indeed could still be voiced in a later one).

Nevertheless, these findings indicate that treatment decision making in the medical encounter is a complex and dynamic process, the course of which is not predictable in advance because no two encounters are exactly the same. Doctors are being urged to practise shared treatment decision making with their patients, and clearly unspoken patient agendas pose barriers to this goal.

*General practice*  
p 1246

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It is now recognised that there are several distinct approaches to treatment decision making that doctors can use with their patients—the paternalistic, the shared, and the informed (or consumerist) approach. Each has different implications for the roles of doctors and patients in communicating information and for the type, amount, and flow of information between the two.<sup>4</sup> Moreover, some approaches are more amenable than others to incorporating patients' voices and eliciting patients' agendas.

Doctors who adopt a paternalistic approach, for example, are unlikely to have much interest in discussing patient concerns expressed "in the voice of the life world."<sup>1</sup> They are more likely to want short descriptions of physical symptoms that they can transform into diagnostic categories. In the "pure type" of this approach doctors can then make a treatment decision that they think is in their patients' best interest without having to explore each patient's values and concerns.

In the informed approach patients are accorded a more active role in both defining the problem for which they want help and in determining appropriate treatment. In the pure type of this approach the doctor's role is limited to providing relevant research information about treatment options and their benefits and risks so that the patient can make an informed decision.

Only in the shared approach do doctors commit themselves to an interactive relationship with patients in developing a treatment recommendation that is consistent with patient values and preferences.<sup>5</sup> To enable this to happen, the doctor needs to create an open atmosphere in which patients can communicate all their agenda items. In this approach information exchange helps the doctor understand the patient and ensures that the patient is informed of treatment options and their risks and benefits. It also allows patients to assess whether they feel they can build a relationship of trust with their doctor.

Actual behaviour, of course, rarely corresponds to ideal types, and most doctor-patient encounters

combine elements from different models.<sup>6</sup> Moreover, the approach adopted at the beginning of an encounter may change as the doctor gains a better sense of whether the patient has a good understanding of the available treatments.

To develop effective interventions to promote better communication, it is useful to explore specific communication patterns within the broader context of the type of decision making process within which communication is embedded. For example, there may be a mismatch between the decision making approach that the doctor wants to use and patients' desire to voice their own agenda in their own words. Understanding the reasons why communication problems occur can help researchers develop interventions designed specifically to address potentially different types of communication issues.<sup>7, 8</sup>

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## Treating hyperhidrosis

*Surgery and botulinum toxin are treatments of choice in severe cases*

Physiological sweating from cutaneous eccrine glands maintains normothermia and skin hydration. Properly hydrated palmar skin contributes to the effectiveness of normal grip and permits tasks such as turning the pages of the *BMJ*. Hyperhidrosis is unphysiological and excessive sweating, which squanders water and electrolytes without compensatory cooling from the latent heat or enthalpy of evaporation. It affects about 1% of the United Kingdom population. What help can be offered to patients with this disabling condition?

Hyperhidrosis commonly affects the palms of the hands, the soles of the feet, or the armpits, but in a small number of patients it occurs over the whole body surface. In most patients palmar and/or axillary hyperhidrosis is the major problem, and it is freedom

from sweating in the hands or armpits that they seek. In some patients hyperhidrosis affects only the hands or armpits or soles of the feet. Patients with palmar hyperhidrosis have a slippery grip and a cold wet handshake, and their sweat drips into computer keyboards, wets paper, and smudges ink. Exuberant axillary and plantar hyperhidrosis stains and damages clothing and shoes. Eccrine sweat is initially odourless, but patients are embarrassed and inconvenienced by having sodden clothing and damp hands.

Conventional medical therapy with anticholinergic drugs or topical aluminium chloride hexahydrate is inconvenient, unpleasant, and temporary. Patients usually stop using anticholinergic drugs because of a dry mouth, and aluminium chloride hexahydrate often